BRISC IN ONTARIO!

Same intervention, different contexts and service providers.
Lessons learned through the implementation of the *Brief Intervention for School Clinicians*.

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Overview

- Setting the Stage:
    - Why choose BRISC?
    - Feasibility pilots: What we wanted to learn in Ontario; Timelines and Expectations

- Methods

- Findings and Questions

- Lessons Learned
    - Implementation, suggestions and testimonials from the field
    - Next Steps

But First a Behind the Scenes Tour

Our diverse settings. Who we are. What is BRISC?

Our Settings

ONTARIO, CANADA

- Population roughly 13.7 million (of Canada's 35.5 million)
- 72 school districts
  - 31 English Public (secular or non-religious: open to all)
  - 29 English Catholic
  - 4 French Public
  - 8 French Catholic
- 5000 schools
- Approximately 2 million students
- Approximately 117,000 teachers
- Approximately 7400 principals/vice principals

Who We Are

SMH ASSIST, SMART Center & UW School of Medicine

School Mental Health ASSIST

Is a provincial implementation support team designed to help Ontario school districts to promote student mental health and well-being.

Through communities of practice, resource development and coaching supports, SMH ASSIST's team helps to bridge the knowledge to action gap.

SMH ASSIST's Areas of Focus

1. Organizational Conditions and Leadership

2. Capacity Building in SMH

3. Implementation Support for Evidence-Based Promotion and Prevention Practices (EBP's)

4. Special Populations

5. System Coordination

6. Youth Engagement

SMH ASSIST Services

➢ **Provincial Leadership in School Mental Health**

> ➢ Systematic, collaborative, intentional, explicit, nuanced, creative, evidence-based

➢ **Implementation Coaching**

> ➢ Province, Region, Board

➢ **Resource Development**

> ➢ Awareness, Literacy, Expertise

➢ **Community of Practice**

> ➢ Meetings, on-line forums

Mission of the SMART Center

…to promote high-quality, culturally-responsive programming to meet the full range of social, emotional, and behavioral (SEB) needs of students in both general and special education contexts.…facilitate more equitable, effective, and integrated approaches to research and technical assistance surrounding the design and implementation of evidence-based SEB interventions.

What is BRISC?

Acknowledgements

Evidence, Key Informants, Expert Summit	Pilot Testing Initial comparison study	ONTARIO SMH ASSIST	Expanded School Based Testing	Multi-site Trial: WA, MD, MN	Train the Trainer Pilot

Access ≠ Effectiveness

1. Access & Utilization of Services

2. Service Quality and Outcomes

MIND THE GAP

BRISC: Finding a "Good Fit" for Schools

School-Based Usual Care	BRISC
Intervention is often crisis-driven	Structured / systematic identification of treatment targets

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BRISC: Finding a "Good Fit" for Schools

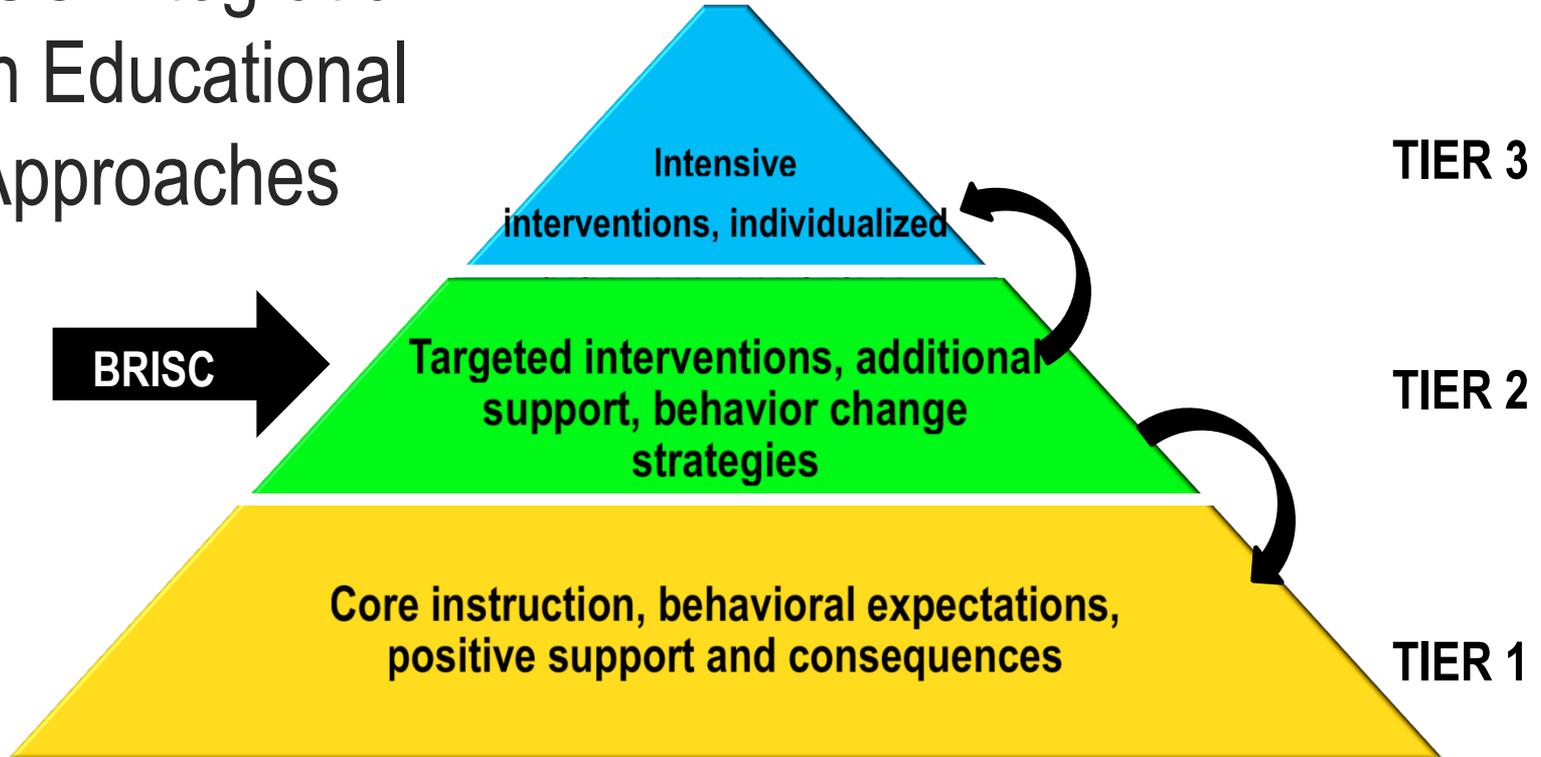| School-Based Usual Care	BRISC
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Standardized assessments are used infrequently	Utilizes standardized assessment tools for progress monitoring

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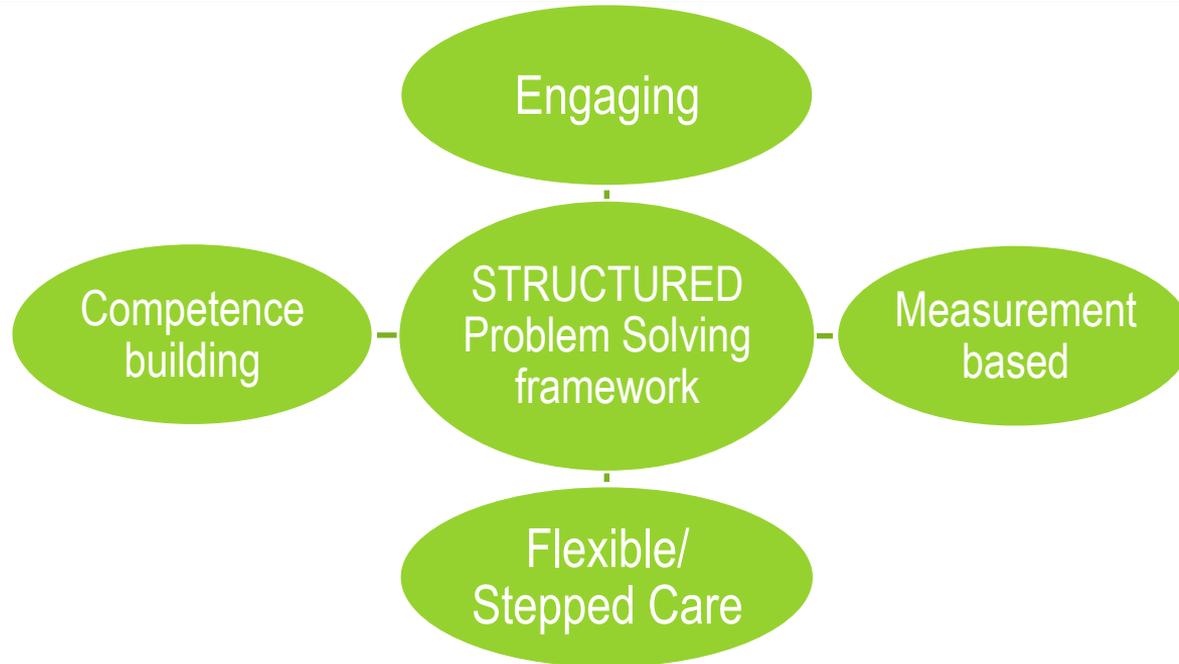| School-Based Usual Care	BRISC
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Many students in need; only a handful get help (many continue after it's needed)	Aimed at efficiency, so the clinician can get to the next student in need

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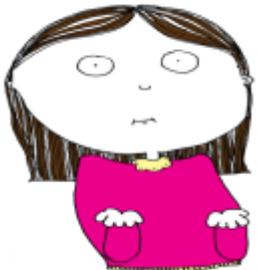| School-Based Usual Care	BRISC
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Standardized assessments are used infrequently	Utilizes standardized assessment tools for progress monitoring
Many students in need; only a handful get help (many continue after it's needed)	Aimed at efficiency, so the clinician can get to the next student in need
Students feel like therapy is just "a lot of talking"	Active engagement of the student by focusing on their needs as they describe them

BRISC Integration with Educational Approaches

SMART
School Mental Health Assessment Research & Training Center

SCHOOL MENTAL HEALTH-ASSIST
ÉQUIPE D'APPUI POUR LA SANTÉ MENTALE DANS LES ÉCOLES

UW Medicine
SCHOOL OF MEDICINE

TIER 3
Intensive interventions, individualized

BRISC

TIER 2
Targeted interventions, additional support, behavior change strategies

TIER 1
Core instruction, behavioral expectations, positive support and consequences

BRISC Guiding Principles

BRISC Session 1

1. Administer and review brief standardized assessment measure(s)

2. Assess current functioning: school, peers, family

3. Identify Problems
   a) List problems
   b) Identify top 3
   c) Introduce cognitive triangle

4. Convey Helpfulness & Plan for Working Together

5. Introduce Informal Monitoring

BRISC Session 2

1. Review informal monitoring

2. Recap problem list and identify problem to address

3. Discuss stress and obtain rating

4. Introduce problem solving

5. **Identify barriers and plan to address**

6. Create a game plan for the week

BRISC Session 3

1. Review problem solving experiment

2. Ask for stress rating

3. **Continue problem solving:**
   a) **Individualize approach based on barriers**
   b) **Incorporate new skill as/if needed:**
      - **Stress and Mood Management Guide**
      - **Communication Skills Guide**
      - **Realistic Thinking Guide**

4. Create game plan for the coming week

BRISC Session 4

1. Assess the outcome of the solution

2. Ask for stress rating

3. Administer and review brief standardized assessment measure

4. Review progress and continued use of problem solving skill

5. Identify and plan for next steps

Post-BRISC Pathways

- ☐ Come back if you need it

- ☐ Ongoing school-based counseling or other school-based services

- ☐ Referral to outside services

- ☐ Regular check-ins (with identified person at school)

Setting the Stage

Why choose BRISC; Feasibility pilots & Implementation Catalysts

Why Choose BRISC?

Alignment is key!

As a province:
- We've set the stage* (10 organizational conditions)
- We're are actively building capacity to ensure that everyday well-being practices are integrated in the fabric of schools

Our next steps
- Introducing an evidence based intervention to identify, triage and intervene with youth at risk
- BRISC offers the rigor and flexibility that our context was ready for. It also builds on current skills of practitioners, but streamlines these in a way that is adapted to school settings.

However, we still needed to adapt BRISC to our context.

Aligned and Integration Model (AIM) for
School Mental Health and Well-Being
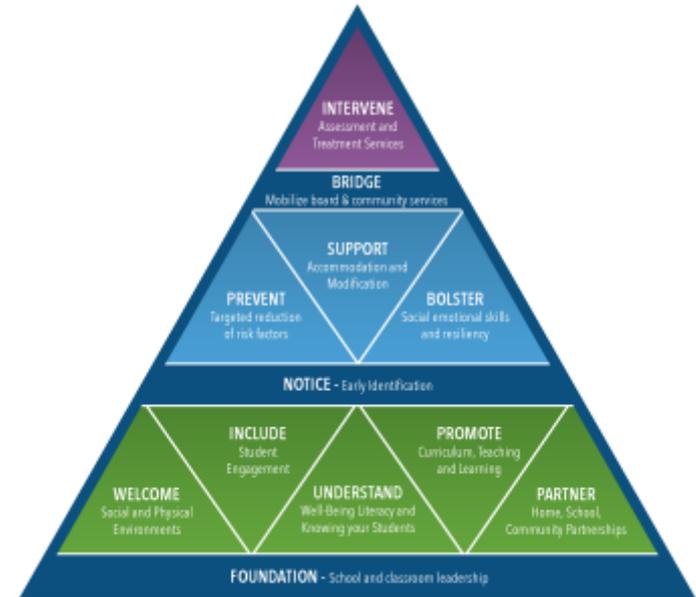
However… We Have a Few Differences

Washington

- Developed in context of School Based Health Centers
    - Clinicians asked to serve all students of all range of needs
- **Most clinicians Master's level**
- Practitioners connected to other services in their home agency
    - Facilitates referrals to other specialists
- **Training and consultation on BRISC conducted by the developers**

Ontario

- Practitioners aren't all Master level clinicians.
- BRISC is tailored for High School students (grades 9+). In Ontario, we tried the approach with younger – more mature – students.
- Two official languages: French and English
- District level differences:
    - Capacity to offer internal MH services
    - Community capacity to offer more intensive supports vary
- Cohort 2: Consultations were offered by in-house BRISC trained practitioners

# Feasibility Pilots of the BRISC Intervention

What we set out to learn.

What We Wanted to Learn…The Purpose of our Pilots

1. What are the presenting needs of students referred to BRISC?

2. With what degree of fidelity do practitioners implement BRISC?

3. What types of modifications do practitioners report?

4. What are the practitioners' perceptions of acceptability and feasibility of BRISC?

5. Is BRISC as effective with students as we try to bring it to scale?

6. What are the post-BRISC service pathways?

7. Do pathway options differ according to professional background? Or depending on available internal and/or external mental health services?

Timelines

Cohort 1 (March 2016)

Exploration

- 12 districts (3/9)
- 1 MHL/supervisor* & 2 Practitioners trained per district
- 34 trained (22 practitioners)
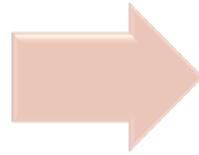
Cohort 2 (Dec. 2016)

Delving deeper

- 9 of the initial districts (2/7)
- 43 practitioners trained

*Why include the MHL/supervisor? To provide support to practitioners when implementing this new intervention. Also promotes a key organizational condition when considering bringing the approach to scale.

Expectations

Cohort 1 (n=22 practitioners)

- 2 students with whom to try BRISC/ practitioner over a 2 months period

- Complete online session fidelity checklists and other pilot related data collection

- Bi-weekly phone consultations with the UW developers

Cohort 2 (n=43 practitioners)

- 5 students with whom to try BRISC/ practitioner over a 6 month period

- Complete online session fidelity checklists and other pilot related data collection

- 10 experienced BRISC practitioners in 9 boards trained as internal consultants
  - Consultants are not the supervisors
  - Consultants meet with team in existing meetings at least 1/month

SMART
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UW Medicine
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We Listened to Cohort 1, then Adapted for Cohort 2

What was said in Cohort 1

- Ensure that *Pathways to care* are clearly articulated

- Ensure that **<u>all</u>** materials are translated **<u>and</u>** adapted

- Involve supervisors more actively

- Practice, Practice, Practice

What we did for Cohort 2

- Provincial deliverable: all districts required to develop and submit a clear *Pathway to, from, and through care*

- All materials were translated and adapted to meet cultural needs

- In-house consultant (non-supervisor) which offered an accessible support

- Modification of the initial training to allow an intuitive approach to the practice of BRISC

Evaluation Methods

Human Subjects Protection and IRB Review

◻ All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional review board (IRB) of the University of Washington

◻ Informed consent for the Washington cohort was obtained for all participants, given these data were collected under the auspice of a federal research study.

◻ Data collection for the Ontario cohort were determined exempt from formal IRB review because it was a quality improvement evaluation of the BRISC intervention in which:

  ◻ data recorded by the investigator in such a manner that participants could not be identified, directly or through identifiers linked to the subjects, and

  ◻ data were collected primarily for the purpose of evaluating public benefit; identifying possible changes in or alternatives to the program.

To Gather Our Information, We:

▢ Assessed perceptions of the quality and impact of BRISC training: IOTTA (Impact of Training and Technical Assistance)

▢ Data for each student served was collected online through a checklist format

  ▢ Initial referral (presenting needs)

  ▢ Practitioner reports per session (Problem solving strategy; PHQ-9; GAD-7; Stress ratings; Fidelity)

  ▢ Discharge information (post-BRISC pathway; modifications/suggestions)

▢ Exit interviews/surveys with practitioners after each Pilot

Findings

Pilots and lessons learned along the way…

Current Samples

Cohort 2*

- 43 practitioners (n=22 data available 63% response rate)
- About 190 students

Cohort 1

- 22 practitioners
- 40 students

Washington State

- 8 clinicians,
- 39 students

Cohort 2

| Initial referral data N=177 | Session 1 data N=190 | Session 2 data N=168 | Session 4 data N=112 | Discharge data N=106 |
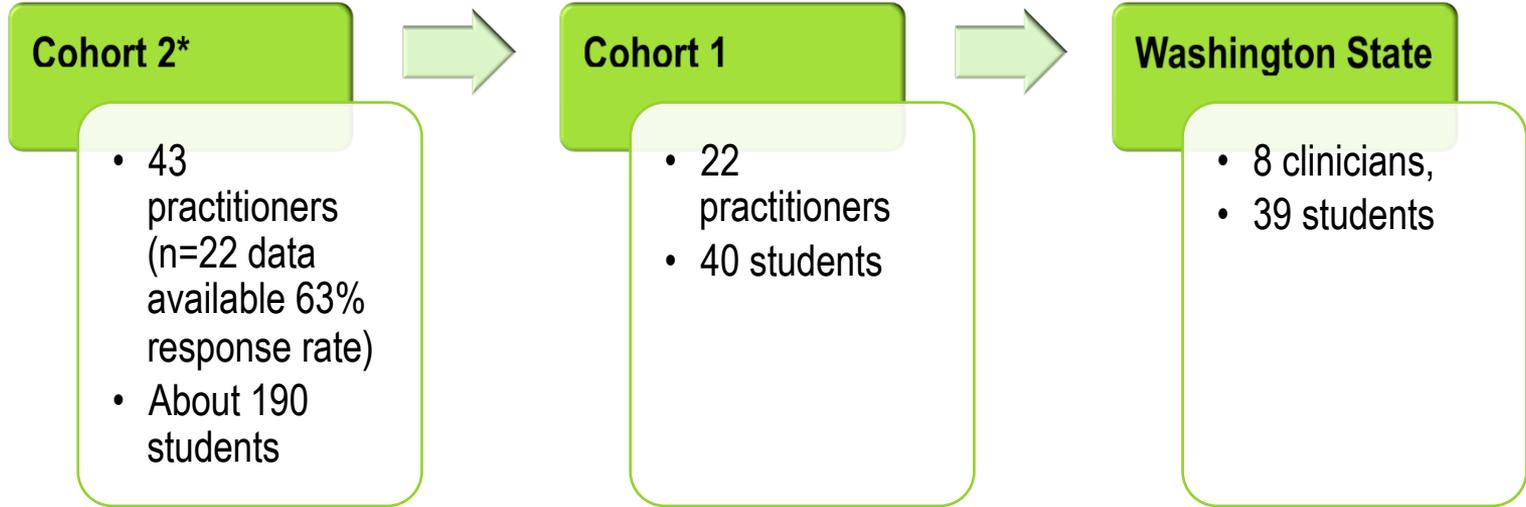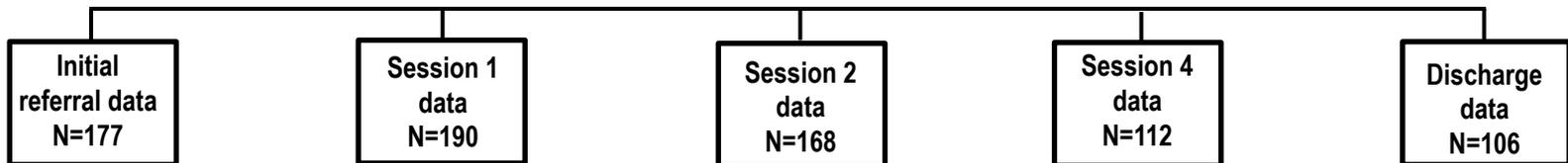
Practitioner Demographics (N=22 respondents)

Age range	
25-44	73%
45-54	22%
55-64	5%
Education	
College	65%
Bachelor's	15%
Master's	20%
Professional categories	18% Social Workers (SW) / 82% Child Youth Workers (CYW)
Years in MH / current position	14 years / 8 years
Francophone/Anglophone	9% / 91%
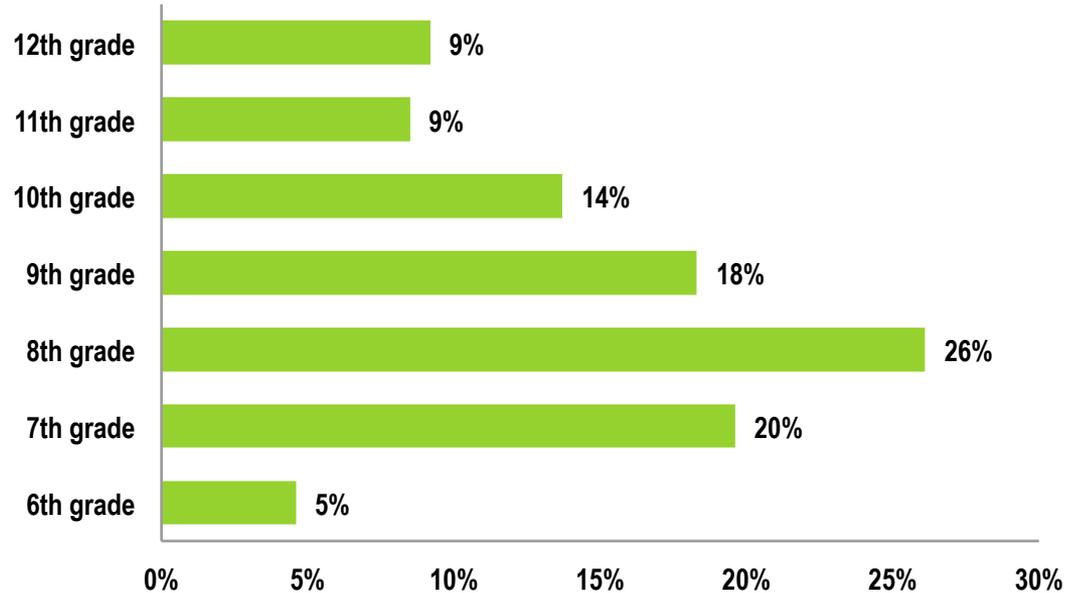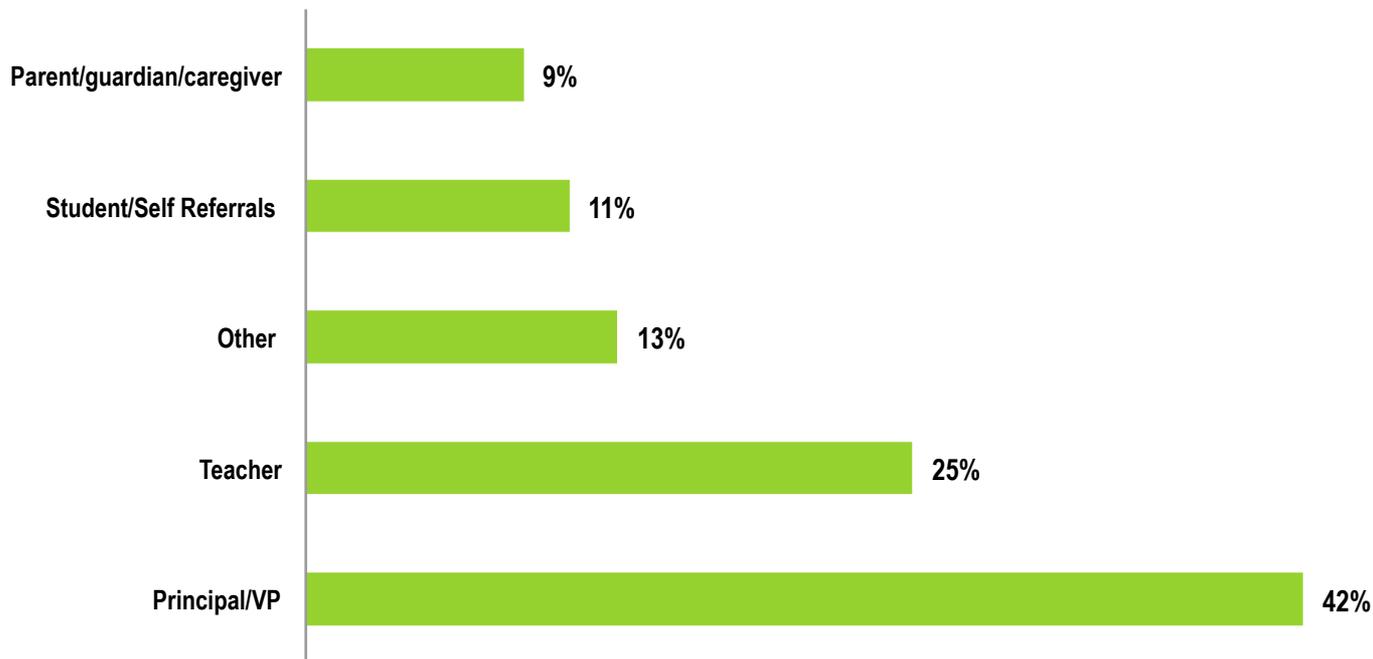
What Are the Presenting Needs?

Results: Presenting Needs of Students

- Students had up to four different presenting needs. For example: A single student may present with internalizing and school problems

  - Only one presenting need = 44% (n=79)

  - Two presenting needs = 42% (n=72)

  - Three presenting needs = 6% (n=13)

  - Four presenting needs = 2% (n=3)

  - Missing info = 6% (n=10)

Presenting Needs of Students (Cohort 2)

Presenting Needs	Frequency
Internalizing Problems (depression, low mood, anxiety, worry, suicidality/self-harm, stress)	99
Relationship Problems (peers, family members, friends, bullying, aloneness, belonging, conflict with others, parents separating or divorcing)	61
School Problems (attendance, classes, teachers, grades/performance, focus and motivation, speaking in class, transportation, international exchange student support)	53
Externalizing Problems (anger, ADHD, drug use, ODD, emotional regulation needs)	30
Trauma, Grief, Loss (death of a parent /relative, tragic accidents)	13
Other Problems (Autism, sleep habits, appearance, home-life)	18

With What Degree of Fidelity do Practitioners Implement BRISC?

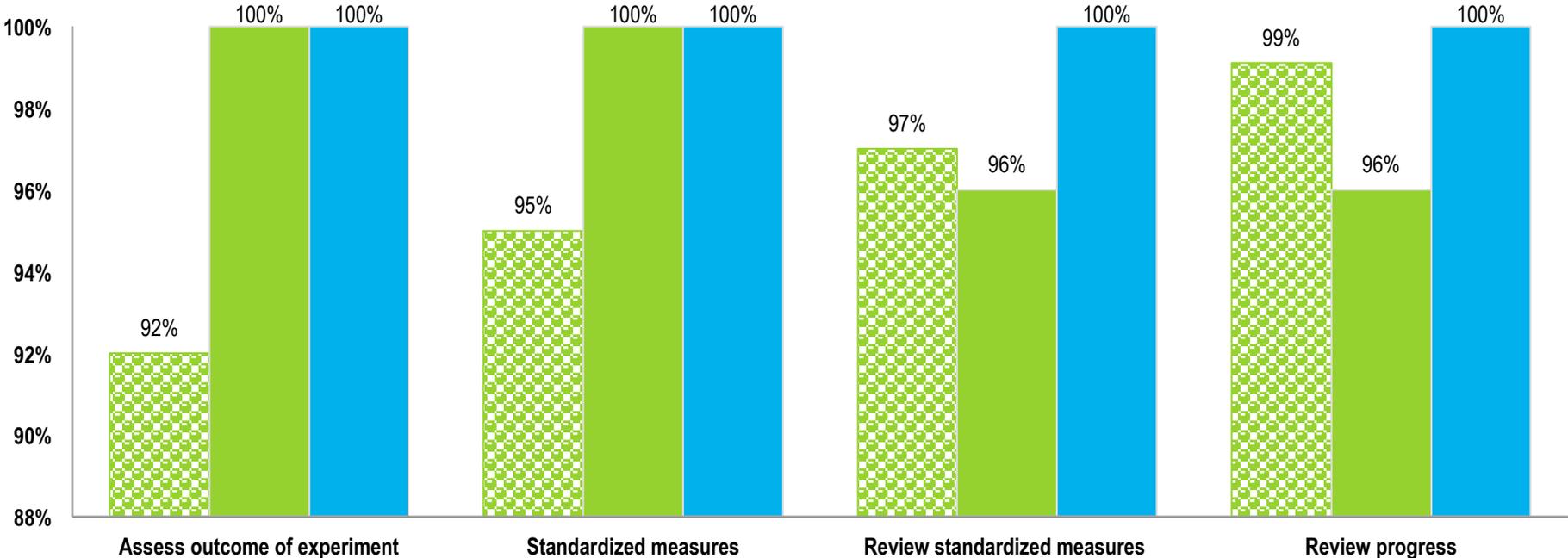Did "Cohort 2" – supported by Ontario consultants – achieve comparable fidelity to Cohort 1?
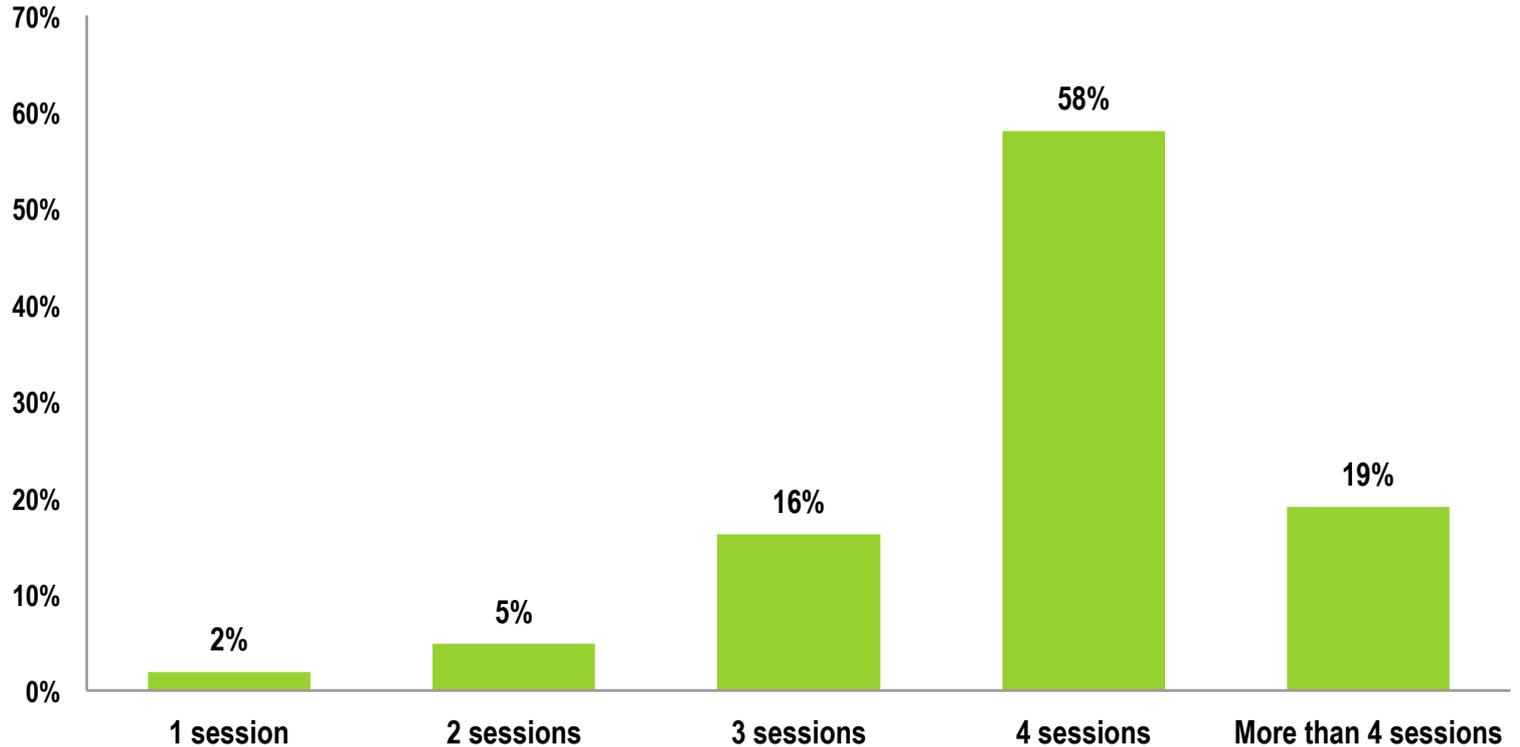
Session 1 elements fidelity comparison (n=190)
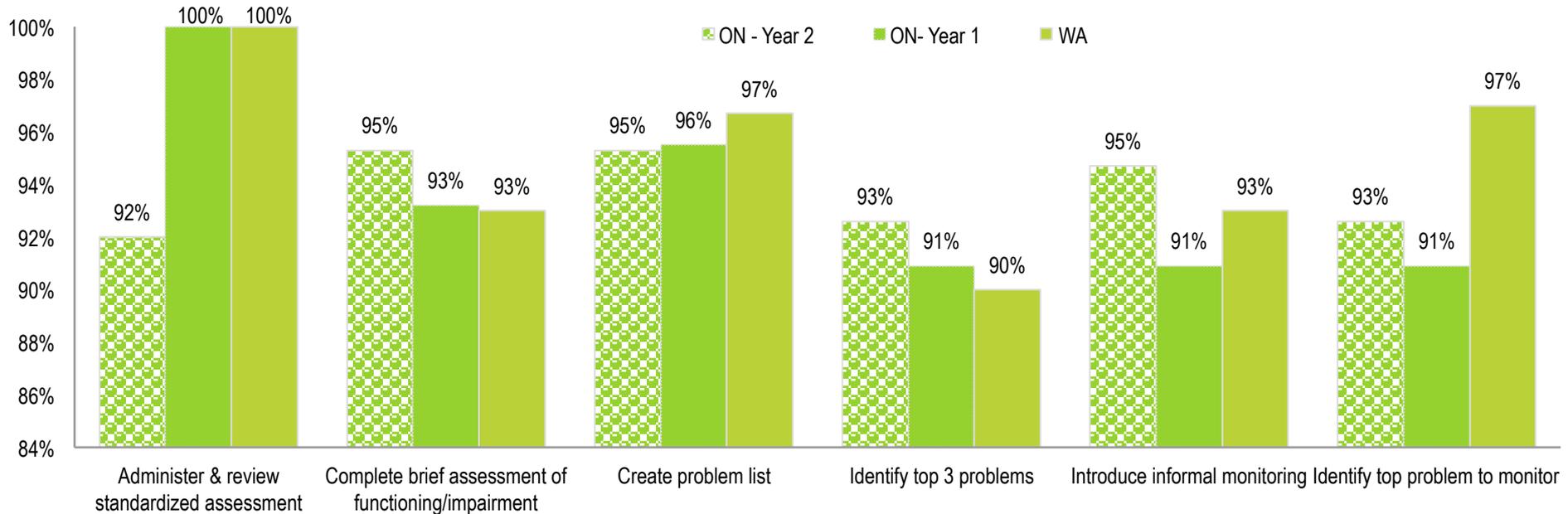
Session 2 elements fidelity comparison (n=168)
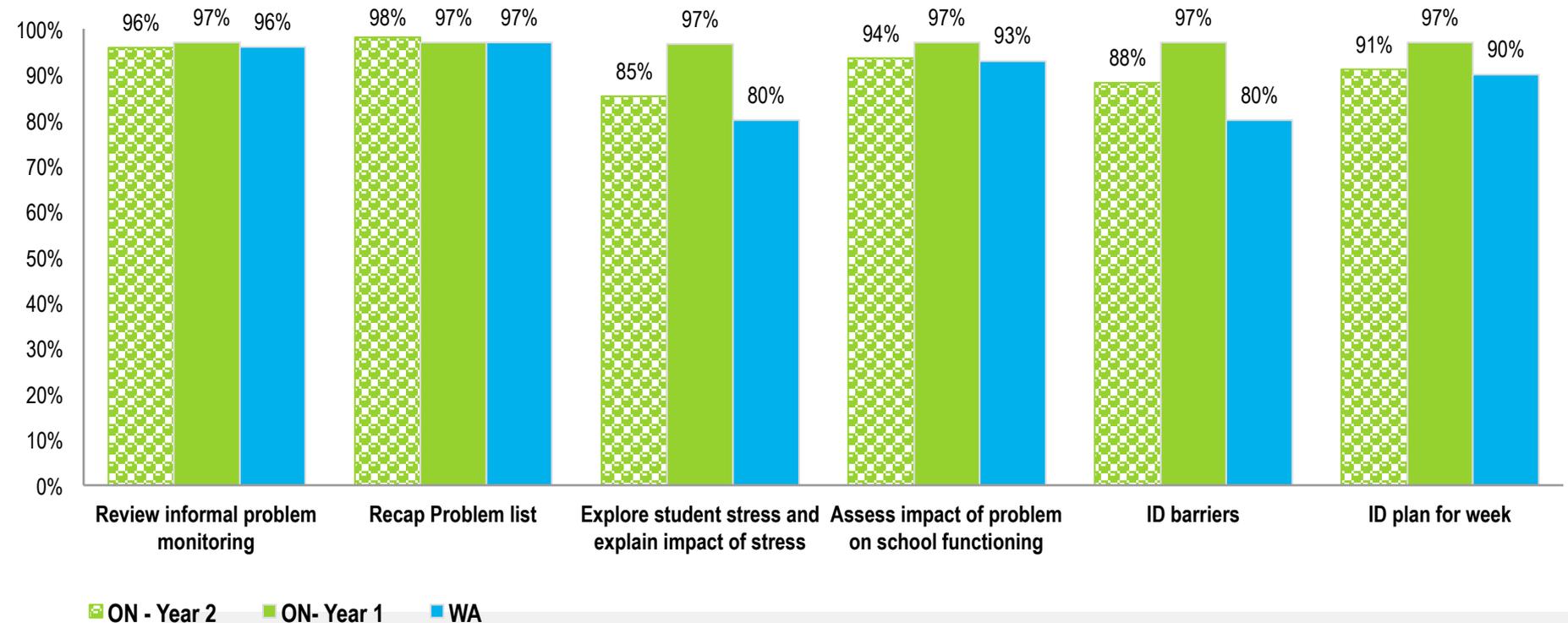
Session 4 elements fidelity comparison (n=112)

Legend: ON - Year 2, ON- Year 1, WA

Element	ON - Year 2	ON- Year 1	WA
Assess outcome of experiment	92%	100%	100%
Standardized measures	95%	100%	100%
Review standardized measures	97%	96%	100%
Review progress	99%	96%	100%

What Types of Modifications do Practitioners Report?

Results: Few Modifications Proposed by Cohort 2

- 100% delivered BRISC protocol in in-person format, individual sessions
- 97% kept the recommended order of sessions
- 20% extended BRISC sessions beyond 4
- 13% substituted elements of a different treatment approach for one of the BRISC elements
- 12% stopped using the BRISC protocol during a session due to crisis or other interruption
- 11% skipped core components of BRISC session
- 9% integrated another treatment approach into BRISC

What Are the Practitioners' Perceptions of Acceptability and Feasibility of BRISC?

Practitioner ratings on discharge forms for each student served

BRISC Feasibility: Discharge Information

Scale: 1 (Not at all) to 3 (Moderately) to 5 (Extremely)	ON (n=106)		ON (n=35)		WA (n=30)	
	Mean	SD	Mean	SD	Mean	SD
Usefulness of BRISC structure and tools in student's treatment	3.90	0.96	3.94	0.73	3.73	0.87
Relevance of problem solving and other tools to this student	3.91	0.99	3.86	0.88	3.70	1.14
Extent to which clinician was able to incorporate BRISC concepts and techniques into their work with this student	3.91	0.91	3.89	0.72	3.70	0.95
Compatibility of BRISC with the practical realities and resources of this case	3.75	1.04	3.89	0.86	4.03	1.22

BRISC Feasibility by language

Scale: 1 (Not at all) to 3 (Moderately) to 5 (Extremely)	English Speakers (n=102)		French Speakers (n=4)	
	Mean	SD	Mean	SD
Usefulness of BRISC structure and tools in student's treatment	3.92	0.95	3.25	0.96
Relevance of problem solving and other tools to this student	3.83	0.99	3.25	0.96
Extent to which clinician was able to incorporate BRISC concepts and techniques into their work with this student	3.93	0.90	3.25	0.96
Compatibility of BRISC with the practical realities and resources of this case	3.77	1.03	3.00	1.16

BRISC Feasibility and Acceptability (from Exit surveys)

| Scale: 0 (Not at all useful) to 10 (Extremely useful)	ON Cohort 1 (n=13)	ON Cohort 2 (n=26)
Usefulness of…	Mean	Mean
Phone consultation received	7.2	6.7
BRISC modules	8.3	7.2
Emphasis on homework exercises	7.2	6.5
Emphasis on progress monitoring and feedback	8.6	8.1
BRISC Problem solving feedback	9.0	7.4

BRISC Feasibility and Acceptability (from Exit surveys)

Scale: 0 (Not at all) to 10 (Extremely)	ON Cohort 1 (n=13)	ON Cohort 2 (n=26)
Other items		
Motivation to continue using BRISC	9.0	7.3
How would you rate your effectiveness using BRISC?	8.0	6.9
What percent of students would benefit from BRISC?	74.7%	54.7%*

*Representative quotes: "Only if the needs are lower level;"
"Great for those with time and not too many high needs students;"
"Might be beneficial to have a screener tool to determine when to use BRISC";
"I see the need for time limited, but [BRISC] actually increased time spent with milder students … the benefit is they may not become intense cases"

Student Mental Health Outcomes

Is BRISC as Effective With Students as We Try to Bring It to Scale?
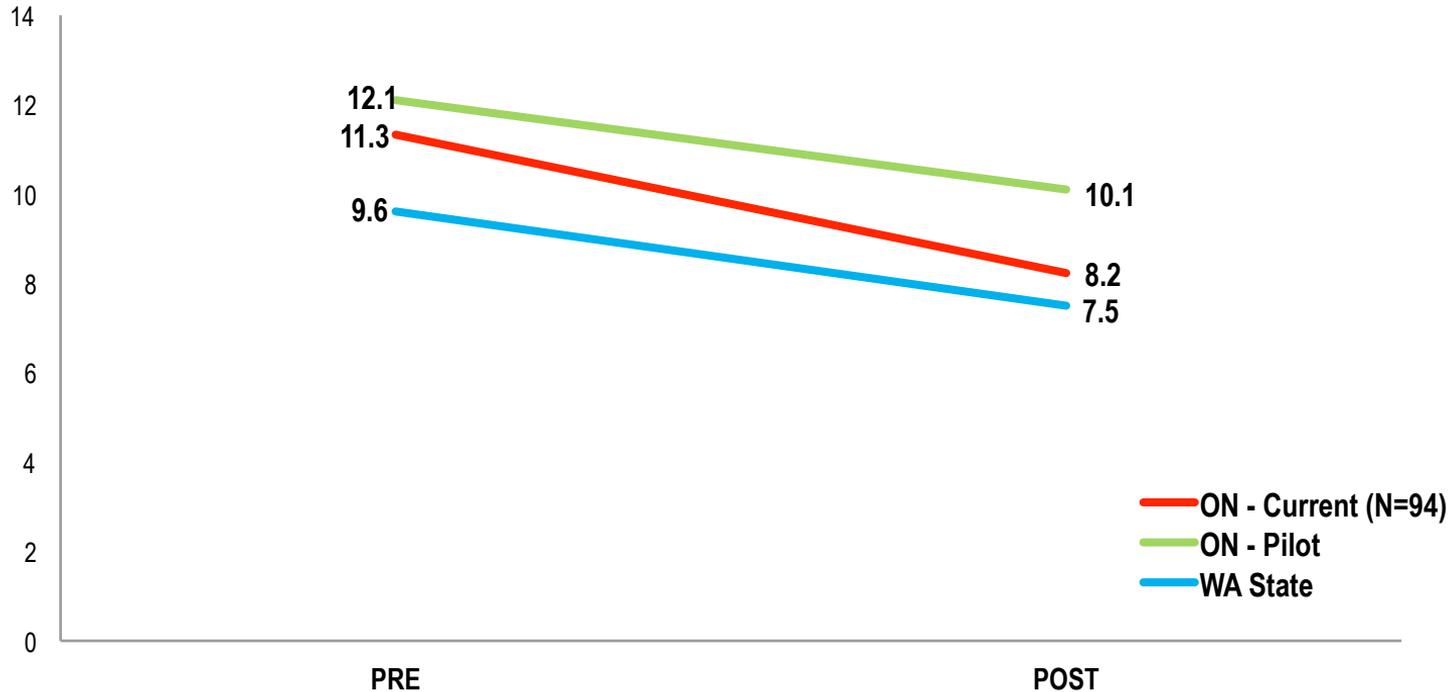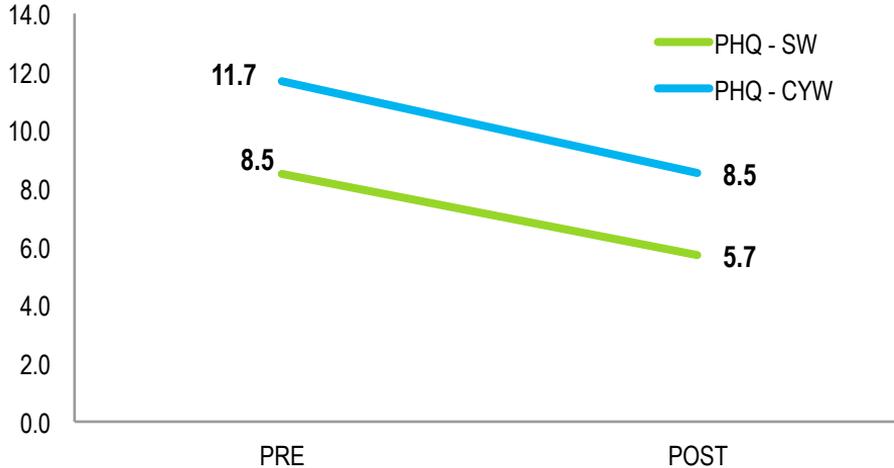
Student outcomes: GAD-7 (Anxiety)
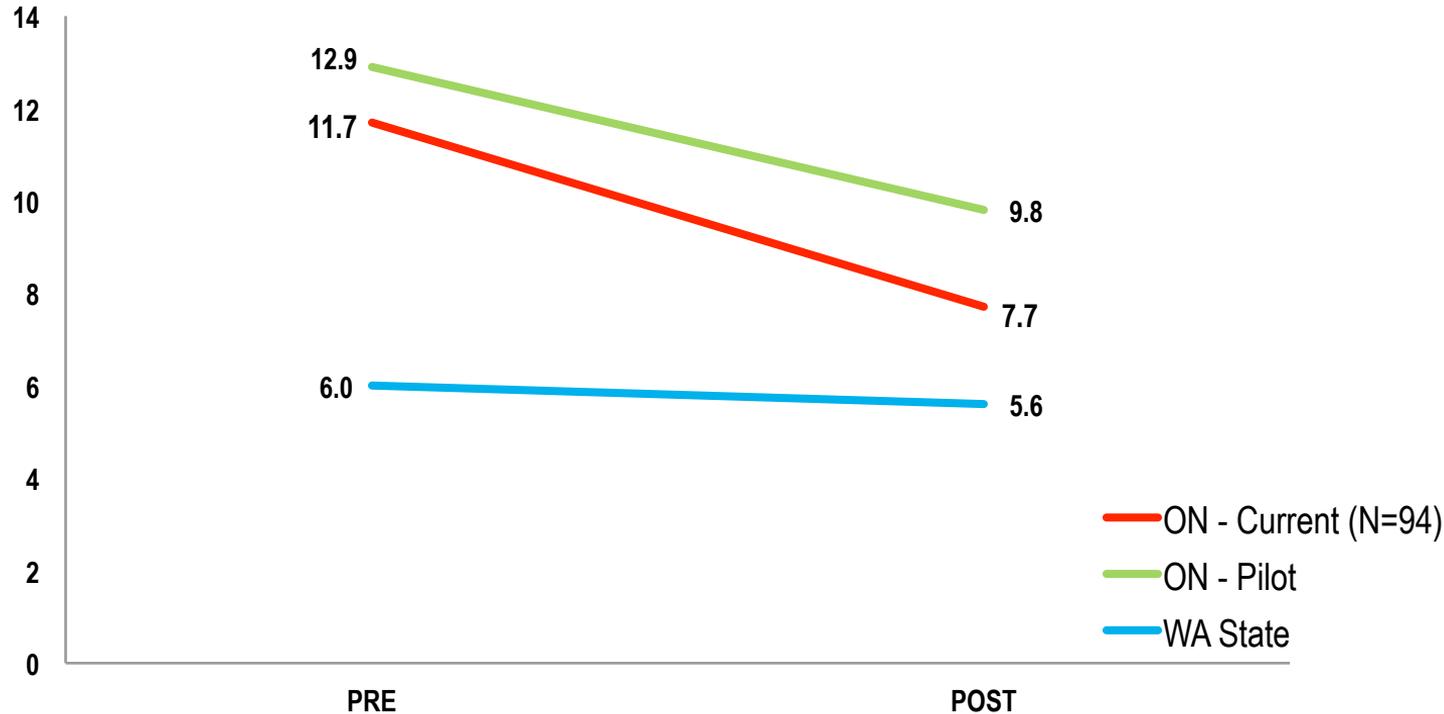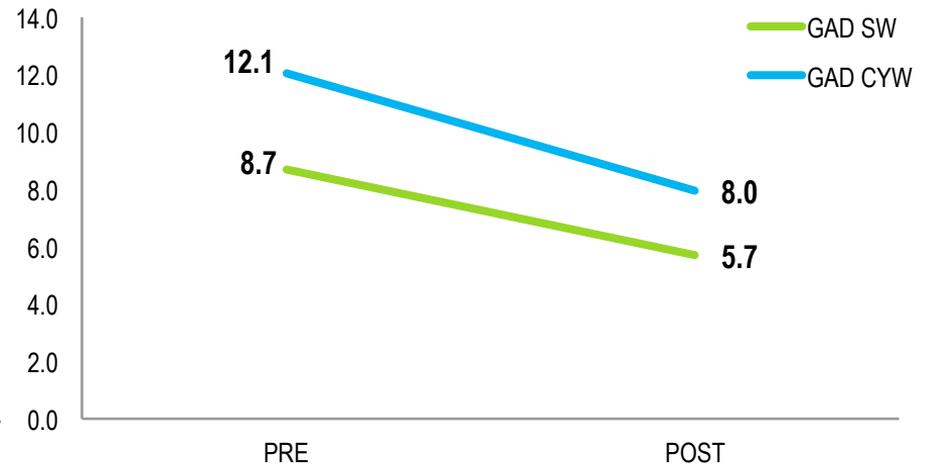
Student outcomes: Stress Rating (Stress)
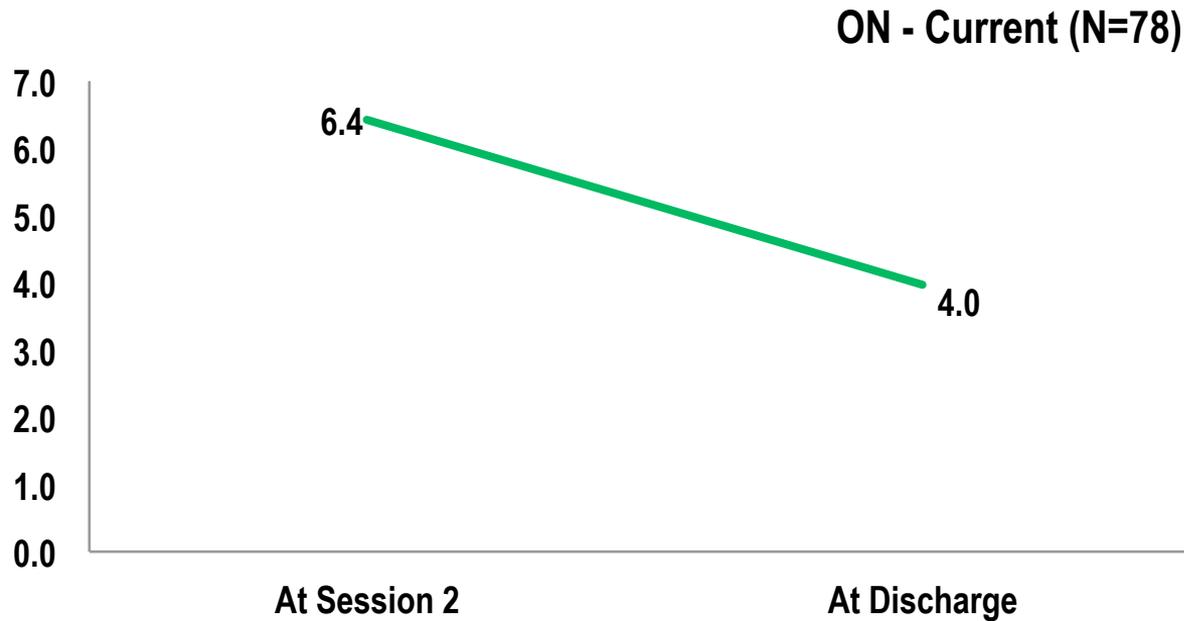
Student outcomes by provider type

PHQ-9 outcomes by providers

PHQ - SW: PRE 8.5, POST 5.7
PHQ - CYW: PRE 11.7, POST 8.5

GAD-7 outcomes by provider type

GAD SW: PRE 8.7, POST 5.7
GAD CYW: PRE 12.1, POST 8.0

Student outcomes by provider type cont.

Stress Rating by provider type
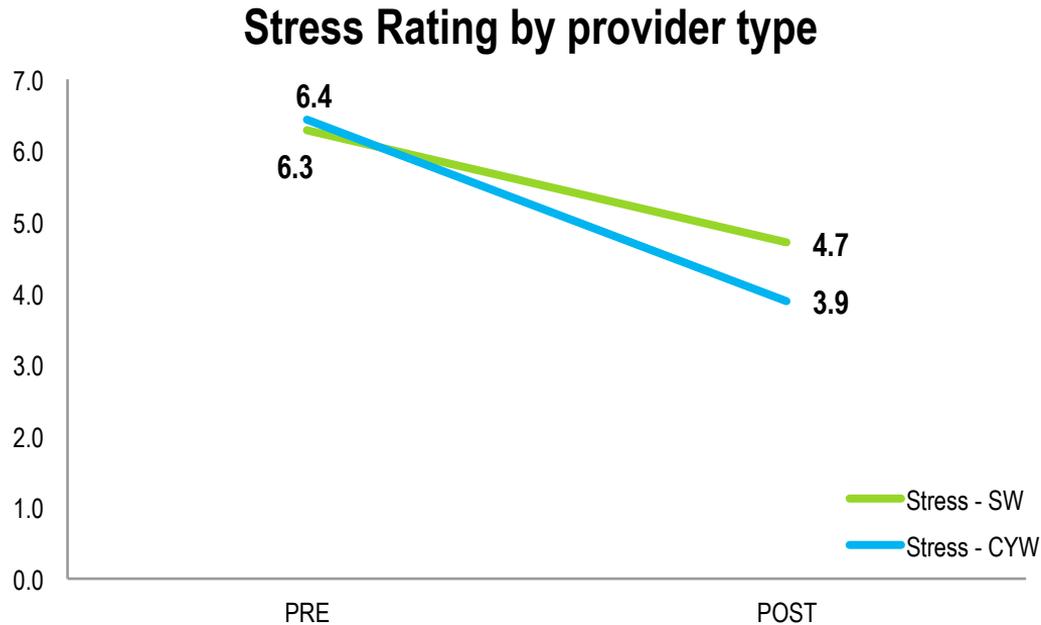
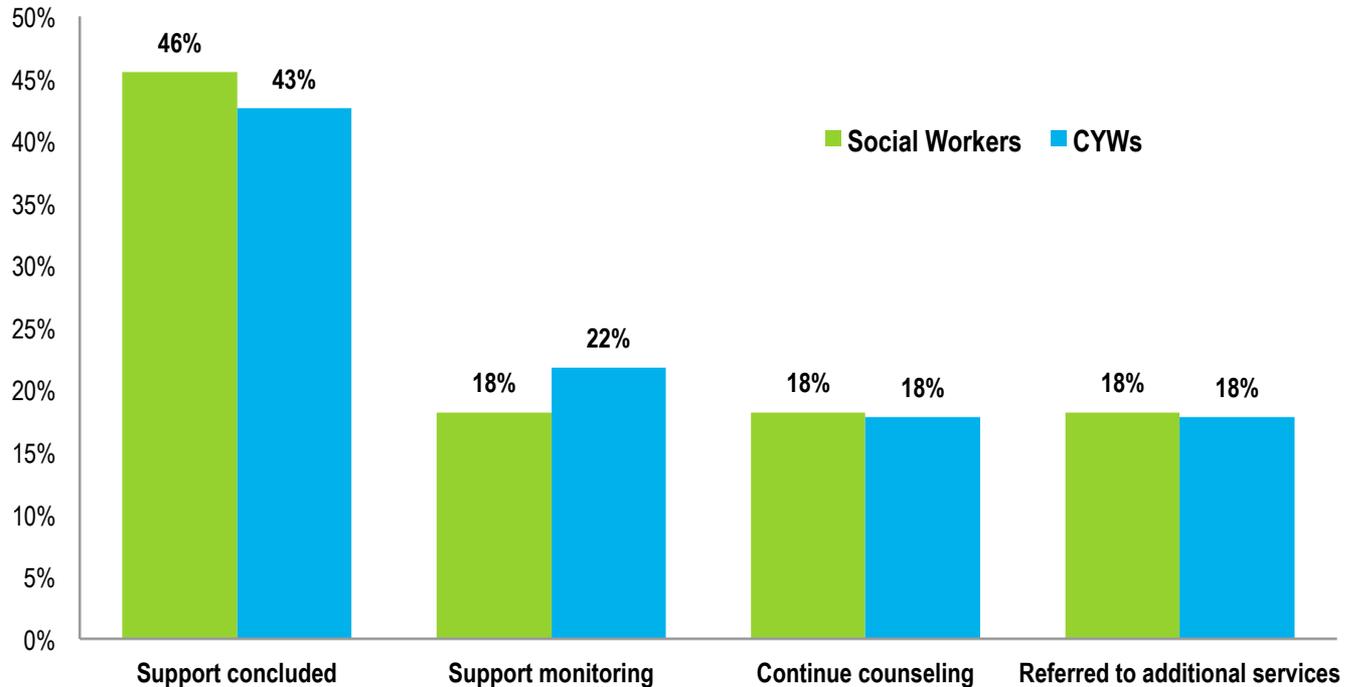# What Are the Post-BRISC Service Pathways?
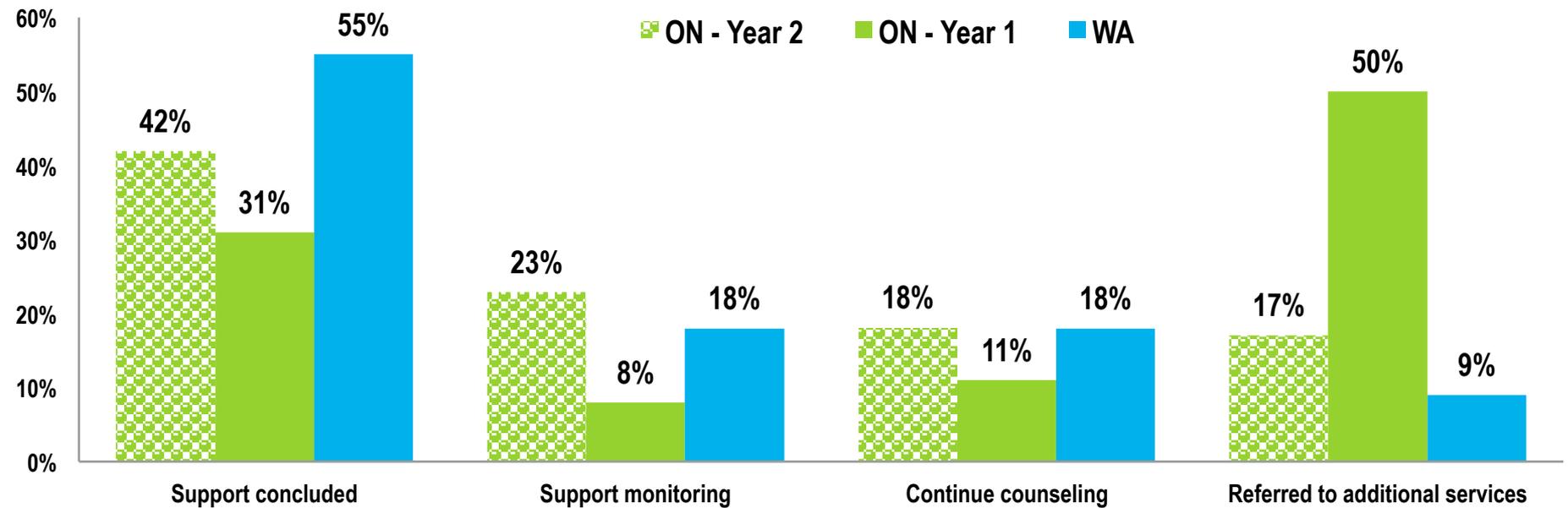
Do Pathway Options Differ According to Professional Background?
Or Depending on Available Internal and/or External Mental Health Services?

Questions. Why…

- …was there a drop in referrals towards external services in Cohort 2?
  - Different students?
  - Different schools?
  - Clearer pathways?
  - Better understanding of what is BRISC and what it isn't?

- …are CYW scores higher at baseline?
  - Are they in different kinds of schools?
  - Do they get referred tougher kids?
    - Yet, they also get the same improvement…

- …is little difference in post-BRISC pathways per profession… but there's a distinctive difference in baseline PHQ-9 and GAD-7 ratings?
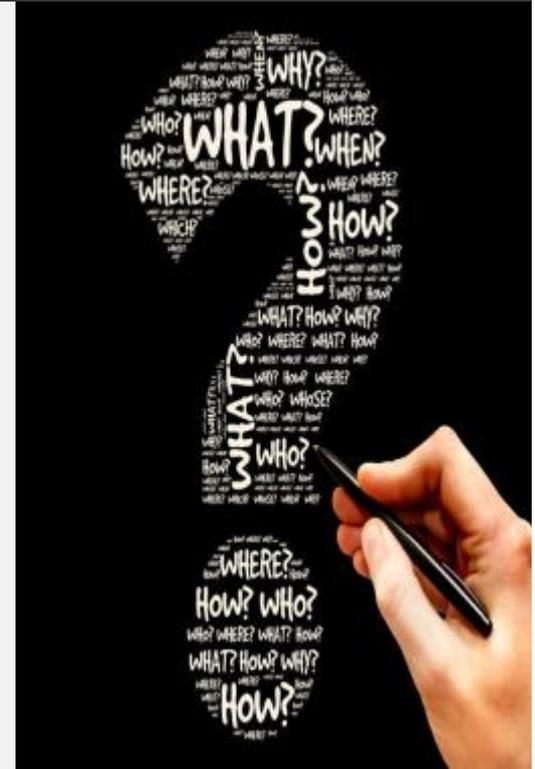
Lessons Learned

Implementation, suggestions and testimonials from the field

Implementation of BRISC: Pros & Cons
From exit surveys and interviews

Pros

- ☐ Structure*

- ☐ Measurement Scales

- ☐ Work Sheets/skills

*However, better understanding of which students to target with BRISC may be needed

Cons (doesn't work as well with…)

- ☐ Time issues (snow days, schedule, number of schools-unable to meet regularly)

- ☐ Attendance issues/students who moved

- ☐ Crisis and high needs

Implementation: Internal Consultants

Benefits

- Accessibility and timeliness of support available

Lessons Learned

- Practitioners may feel less well supported and understand the rationale for BRISC less (feasibility ratings lower for Cohort 2 in Exit Surveys)

- Motivation to continue to use the approach is less in Cohort 2 (as per Exit Survey)

- Clarity of the approach (when/how to use the intervention, wasn't as evident than with Cohort 1)

- Peer-to-peer support is well received, but preferable to have a supervisor support staff, as there were union issues that arose with this model

Suggestions From the Field

- Condensing *Problem solving* worksheet (to reduce perceived redundancy)

- Include prompts on the worksheets

- Consider reorganizing sessions (e.g. introducing skills prior to problem solving)

- Start using BRISC at the beginning of the school year (not part way through)

Testimonials

◻ "I believe it's important for students to understand that Mental Health supports are not intended to be permanent support structures throughout their academic careers. I believe it's important for students to experience 'graduating' from needing Mental Health support as they learn new ways of coping and that they see that they are capable of functioning well without being constantly involved in services."

◻ "Allowing the students the opportunity to gain some skills and tools when they leave the session, as opposed to leaving the room and feeling as though they just spent time talking and gaining nothing."

Testimonials (con't)

- "I like that it is 4 sessions and promotes independent thinking and problem solving, but with the support of an adult."

- "There is a need for time limited intervention, but I didn't feel like this reduced time with students. Actually, it increased time with milder students but a benefit of that is they then have the potential of not becoming intense cases."

- "I like the concept of time limited service as it allows you to serve more students ideally; however, it is not applicable in all situations. I also like that it is very task focused and goal driven and in the right situation with the right kid it is very effective."

Next Steps: Scaling Up

Preparing for Scaling Up: Looking to the Future

Cohort 3 (n=21 new districts)

- 81 practitioners trained from new districts

- 3-5 students with whom to try BRISC/ practitioner over a 5 months period

- **Supervisor training** to support the implementation of BRISC (specific post-training offered to this cohort)

- Monthly consultations will support Supervisors

Train-the-trainer Pilot (n=5)

- 6 practitioners from 5 boards participated in the first iteration of the train the trainer (only in English)

- A spring 2018 training will further refine the model to ensure proficiency in facilitating the approach. A stepped approach is suggested (e.g. must meet certain requirements prior to taking part in the train-the-trainer)

STAY TUNED!

Thank You!

http://smh-assist.ca
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